AEFFECTIVE USE OF VOLUNTEERS IN CHIP/MEDICAID OUTREACH AND ENROLLMENT@ B APRIL 22, 1999 HIGHLIGHTS OF THE TECHNICAL ADVISORY PANEL MEETING #6 (LOUISIANA, MARYLAND, NEW MEXICO, AND PENNSYLVANIA)

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Opening Remarks

Mr. Richard Fenton, Deputy Director of the Health Care Financing Administration's (HCFA) Family and Children's Health Programs Group, opened the Technical Advisory Panel (TAP) meeting. He indicated that States have been working diligently to operationalize the Children's Health Insurance Program (CHIP) legislation that was enacted by Congress and the President in August of 1997. He noted that, at this point in time, "the restaurant has been built, the tables have been set, and the cooks and waiters are ready to go – what is needed are the customers." Most States have a CHIP infrastructure in place and it is now time to focus upon enrolling eligible children into CHIP/Medicaid and assuring that these enrolled children are receiving services. This TAP, focusing upon the use of grass-roots efforts with volunteers, is helpful in the continuing effort to enroll eligible children into CHIP/Medicaid.

Dr. Lillian Gibbons, of HCFA, and Ms. Carol Galaty, of the Health Resources and Services Administration (HRSA) then welcomed TAP participants (see **Attachment 1** for a listing of TAP attendees). Dr. Lillian Gibbons introduced the two guest speakers of the TAP, Ms. Betty Bumpers, co-founder of the *Every Child by Two* immunization campaign, and Ms. Sarah Katz, co-coordinator of the *Student Health Outreach Project* with the Children's Defense Fund New York (CDF-NY) Office. These speakers each bring a national perspective to the TAP discussion and the ability to identify common themes.

State Overviews of Use of Volunteers for CHIP/Medicaid Outreach

TAP participants from each of the invited States--Louisiana, Maryland, New Mexico, Pennsylvania--gave an overview of how they have used volunteers for CHIP/Medicaid outreach. Each State discussed its use of volunteers, highlighting the following topics: the types of volunteer groups with which the State is working; how volunteers are recruited; the training of volunteers; the monitoring of volunteers; the retention of volunteers; future plans to work with other volunteer groups; and the pros and cons of using volunteers. Detailed descriptions of each State's presentation, as well as questions and answers related to a State's presentation, are contained in **Attachment 2**.

Panel Discussion: Lessons Learned from a National Perspective on the Use of Volunteers for Outreach (Mrs. Betty Bumpers and Ms. Sarah Katz)

Mrs. Betty Bumpers, co-founder of *Every Child By Two,* and Ms. Sarah Katz, co-coordinator of CDF-NY's *Student Health Outreach Project* provided a national perspective on the use of volunteers to conduct outreach. Mrs. Betty Bumpers, former First Lady of Arkansas and wife of Arkansas Senator Dale Bumpers, began the Panel by discussing the National Immunization Program, *Every Child By Two* (ECBT), and how aspects of that program relate to CHIP/Medicaid outreach.

<u>History of ECBT</u>

Mrs. Bumpers has advocated passionately for immunization programs for children for the past three decades. In the early 1970s, then Governor Dale Bumpers and Mrs. Bumpers implemented an immunization model in Arkansas that required all children to provide proof of immunization before entering first grade. As part of Mrs. Bumper=s efforts to raise awareness for the need for immunizations, she asked Mrs. Rosalynn Carter, then First Lady of the United States, to join this cause and be a spokesperson for immunizations. Mrs. Carter agreed, and along with Mrs. Bumpers, became a prominent advocate for implementation of national immunization programs and laws. Together, Mrs. Bumpers and Mrs. Carter were responsible for creating the 1977 National Childhood Immunization Initiative, which mandated vaccination at school entry for every child. To ensure immunizations are available, schools and providers have formed coalitions to provide immunization services. As a result of this initiative, each of the 50 States passed laws requiring all children to be immunized before enrolling in school.[1] While these laws increased immunization rates, the United States currently has a 95 percent plus immunization rate for children entering schools, there was the undesirable effect of families believing that their children should be immunized by age five rather than by age two.

This shift in thinking was highlighted by a measles epidemic from 1989 to 1991 that resulted in 55,000 reported cases and 150 deaths. In 1991, in response to the measles epidemic and in an effort to reduce infant mortality through immunizations, Mrs. Bumpers and Mrs. Carter co-founded ECBT in cooperation with the Centers for Disease Control (CDC). The motto of ECBT is Abefore school, before two.@ ECBT is built on a three-tiered approach of setting up, educating, and providing immunizations through the Offices of Child Health Affairs.

Why ECBT is Successful

Mrs. Bumpers credits ECBT=s effectiveness and success to strong partnerships and coalitions. In addition to enlisting Mrs. Carter=s help to promote ECBT, Mrs. Bumpers also took advantage of her connections with influential partners, such as gubernatorial and congressional spouses, elected officials, concerned community leaders, and representatives of many national organizations, to form coalitions. These coalitions have raised awareness of the need for timely immunizations and have been instrumental in institutionalizing a nationwide immunization delivery model. Mrs. Bumpers noted that currently each coalition member has immunization levels between 88 and 90 percent. This rise in immunization is impressive when one considers that ECBT started with Houston, a city where the immunization rate for children under two was 14 percent.

Goals of ECBT

The two main goals of ECBT are ***to raise awareness of the need for timely immunizations*** (shifting the public=s thinking back to immunizing children by age two) and ***to institutionalize partners and ideas*** to ensure that a systematic process is in place to immunize all children by the age of two. In some respects the ECBT goals can be applied to States= Children=s Health Insurance Programs (CHIP). Since CHIP is a new program, it lacks institutionalization. Some States only

[1] In 1979 only 11 schools required that children be immunized before enrolling in school.

recently received approval for their CHIP plans. CHIP needs to be institutionalized and establish deep roots to ensure that the CHIP program and its goals are not eradicated when interest wanes and funding stops.

A related factor to institutionalizing CHIP is that often individuals cannot get proper access to medical care. During the polio and chicken pox out breaks, providers went to children. Now, families must bring their children to providers**C**from some this can involve two bus rides, one subway ride, and a cab fare as many public health facilities, managed care organizations, and hospitals have built facilities removed from public transportation lines. One logical place where children are found is in schools, a primary site for institutionalizing CHIP.

Why are school systems a great place to institutionalize CHIP? For several reasons: schools are permanent institutions; schools are a familiar and trusted institution; and schools exist in every community. For example, Mrs. Bumpers recalled how she had contacted the Secretary of Education several times to promote the implementation of immunization clinics in schools. She stressed that this would not result in additional duties for teachers--the school had only to provide a space where providers could be invited once a month to give immunizations and screenings to infants. In addition, schools know the populations they serve and are in a position to share this information with medical providers to improve public health. While schools may not be the overall answer, they are a place to start to bring cohesion to the fragmented health care delivery system now in place.

Question and Answer Session

The following issues/questions, presented in a ›Q&A: format, were raised during Ms. Bumper=s presentation:

Q: ***What was the process used to persuade Governors= wives to adopt immunizations as a cause?***

A: Mrs. Bumpers commented that Governors= wives want to get involved in public issues and are usually looking for good causes to advocate and promote. When recruiting the wives of State Governors, as well as the wives of Senators and Representatives, it was critical to:

- Assure them of success by promoting a topic that would not involve taking a risk nor be considered controversial;
- Provide them with a topic that offered high visibility and high credibility that they could comfortably endorse; and
- Provide them with all the necessary information, from background materials to speeches, that they could easily understand and communicate confidently to others.

Mrs. Bumpers further suggested working within a State rather than through national organizations such as the National Governor=s Association.

Q: ***What are some successful strategies to get volunteers invested in a cause so that they are inclined to stay?***

A: Mrs. Bumpers noted that national or local groups, such as the Kiwanis and Rotary Clubs, are often looking for causes to adopt. These groups are Aready and willing@ to help and would enthusiastically offer their time as volunteers. States should also target civic, social, and religious organizations, as well as individuals who have made a social commitment to children, to find caring volunteers who would be willing to invest in the cause. Groups dealing with welfare-to-work, as well as AmeriCorps, would be helpful to States= asking for volunteers. Once these volunteers agree to participate, it is imperative for States to make them feel connected and valued.

States should consider the following points:

- Do not give volunteers Athe scut work@ but rather provide them with explicit jobs that are meaningful to them;
- Provide good guidance**C**States should do the Aleg work@ of translating rules and regulations into an understandable format so that volunteers do not feel like they are taking a college class;
- Follow-up with volunteers**C**do they need more materials? are they comfortable with their tasks?; and
- Provide, if funding permits, dedicated workspace and phones as these features are important to volunteers to feel good about their work.

General Issue Discussed: States should identify and establish relationships with key individuals affiliated with CHIP.

A: For example:

- The State Health Officer, who is appointed by the Governor, is responsible for a State=s immunization program. A Governor=s spouse indicating interest in children=s immunizations is indirectly putting pressure on the State Health Officer to improve immunization rates.
- For Congressional offices, the key point of contact is the staff person. States need to determine the equivalent positions for CHIP.

General Issue Discussed: Public recognition of volunteers is important.

A: ECBT recognizes volunteer groups and organizations for their efforts by honoring them with plaques at award ceremonies or by praising them on a daily basis.

ECBT Presentation Conclusion

Mrs. Bumpers= presentation concluded with the following general comments:

- Creating partnerships with key figures, like the Governor, are beneficial to State CHIP outreach and enrollment strategies. For example, Governor Tom Ridge of Pennsylvania is extremely supportive and plays an active role in promoting Pennsylvania=s Children=s Health Insurance Program. The Governor=s involvement makes a difference when individuals are learning about the program. In addition, schools in Pennsylvania have a good relationship with Pennsylvania=s Department of Insurance and are launching a joint program, in the Fall of 1999, to share

information within the school system.

- Different populations require different strategies. For instance, in one State it may be effective to go through the State Superintendent, while in another State it may be more effective to go through the school principals.

SHOUT Program Overview

Ms. Sarah Katz presented a summary of a pilot program being conducted in targeted New York City communities that uses the volunteer efforts of University students to reach out, screen, and enroll uninsured children into Medicaid or Child Health Plus (based upon the report *"Student Health Outreach Project (SHOUT)"*,[2] which the following summary draws upon).

In September 1998, CDF-NY, community-based organizations (CBOs), and students from Columbia University implemented an innovative outreach and enrollment pilot program targeting uninsured children in the Washington Heights and Inwood communities. The objective of this project is to use University students placed within the targeted communities to reach and enroll eligible children in Medicaid or Child Health Plus, New York's two publicly funded health insurance programs for children. SHOUT trains student volunteers to work in CBOs, educating families about Medicaid or Child Health Plus, screening families for eligibility for either program, and assisting families with the enrollment process. Each SHOUT student dedicates two hours per week to a designated CBO. Collectively, the students and CBOs serve as a reliable, trusted, and continuous source of Medicaid and Child Health Plus information.

SHOUT Partnerships

Each entity below plays a distinct role in the successful execution of this pilot project:

- **Columbia University.** Students offer tremendous energy, creativity, idealism, intelligence, and an extensive volunteer capacity to the project. The University administration and faculty bring back-up resources, technical expertise, and support to the project, thus promoting SHOUT throughout the University system.
- **Community-Based Organizations.** CBOs, because they know the families they service and how these families may be reached, are a logical partner in an outreach and enrollment campaign. In addition, they offer a steady stream of children and families seeking services while providing a trusted environment. The CBOs, whom previously worked together on immunization issues, expressed the desire to expand their services to children's health insurance.
- **Children's Defense Fund-NY.** CDF-NY serves as the facilitator and organizer for SHOUT. In this capacity, CDF-NY is responsible for providing several key services including staffing resources to oversee/coordinate day-to-day activities and technical support to the students/CBOs through training and material development. CDF-NY was key in convening the necessary

[2] Children's Defense Fund-New York, *"Student Health Outreach Project (SHOUT)"*, February 18, 1999. For a copy of the report, visit www.childrensdefense.org/whatsworking/1999_0512.html.

government agencies, along with Columbia University and the CBOs, to make the pilot project a realization.

Program Goals and Structure

SHOUT=s goal is ***to enroll children in New York=s two public health insurance programs, Medicaid and Child Health Plus, by addressing the primary reasons for under-utilization--lack of information and lack of access to enrollment sites that are convenient and staffed with trusting and knowledgeable individuals***. To address these barriers to enrollment, SHOUT first conducted an extensive, multi-faceted outreach campaign. The SHOUT outreach campaign included the development and distribution of a flyer. Since September 1998, between 40,000 to 50,000 SHOUT flyers have been distributed by high school students from APrep for Prep,@ whose efforts were organized by the volunteer students from Columbia University. APrep for Prep@ students proactively distributed the flyers in a multitude of venues, from beauty shops to convenience stores, using a variety of approaches, from door-to-door to attending community events.

Once families are made aware of the availability of the health insurance programs, the SHOUT model provides for facilitated enrollment through an active network of volunteers, located at CBOs, working directly with families on an on-going basis to enroll their children in Medicaid or Child Health Plus. By integrating education with enrollment, rather than treating each as a separate activity, the SHOUT enrollment model is structured to minimize the enrollment process for families while maximizing the number of children enrolled in either Medicaid or Child Health Plus. SHOUT includes the following features:

- Community-based enrollment in familiar and trusted settings, such as schools and clinics, that offer non-traditional hours;
- Personalized assistance and counseling to help families understand the Medicaid and Child Health Plus programs and the different services available;
- Authorization to conduct the face-to-face Medicaid interviews, with CDF-NY providing quality oversight;
- Documentation assistance to ensure the availability of all required documentation; and
- Follow-up with families, such as phone calls, letters, and additional appointments, to ensure families complete the application process.

The SHOUT pilot also tests the feasibility of two other components of successful outreach and enrollment processes, a Volunteer-Supervisor Model for Enrollment and a single application applicable to both Medicaid and Child Health Plus. The Volunteer Supervisor Model for Enrollment tests whether a vast network of volunteers, while appropriately trained, can effectively understand the complex Medicaid and Child Health Plus enrollment process and serve as effective enrollers. Beginning in December 1998, the New York State Department of Health gave SHOUT the opportunity to pilot a single application prior to statewide release in the Fall of 1999.

Student Involvement. Columbia University willingly entered into collaboration with CDF-NY to implement SHOUT by offering its administration, facilities, resources, and undergraduate and graduate student bodies. Key features of student training, structure, and supervision include:

- CDF-NY trains all student volunteers. The initial training consisted of 6 hours of classroom time, followed by two weeks of role-playing. Since then, the majority of training has shifted from the classroom to the enrollment sites, and newly recruited students now attend three hours of classroom instruction. The training provides detailed accounts of New York=s Medicaid and Child Health Plus programs, including eligibility requirements, program structures and benefits, and application processes, as well as sessions on sensitivity.
- All student volunteers work in teams of two, two hours per week, and go to the same place each week to ensure continuity. In areas of large minority populations, half of each student team is bilingual.
- Supervisors for the students are available on-site and are either an older student or a staff member of the CBO. Each Supervisor is fluent in English and Spanish. The Supervisor serves as a liaison between the CBO and CDF-NY.

Community-Based Organization Involvement. SHOUT grew out of a desire by CBOs to expand their health insurance enrollment opportunities in their communities, and their frustration that limited resources prevented them from enrolling children on their own. The CBOs are known and trusted by families and are an integral part of the neighborhoods they serve. When SHOUT was implemented, in September of 1998, three CBOs in Washington Heights hosted student volunteers; in January of 1999, SHOUT expanded into Central Harlem with four CBOs hosting student volunteers.

CDF-NY=s Involvement. CDF-NY[3], through SHOUT, has been able to develop a replicable model involving student volunteers situated within CBOs for enrollment into New York=s Medicaid and Child Health Plus programs. The roles CDF-NY has assumed include:

- Serving as the liaison to the CBOs and the student campuses;
- Recruiting students and coordinating their schedules with the CBOs;
- Establishing the roles and responsibilities of both the students and the CBOs;
- Working with the New York State Department of Health to pilot the single Medicaid/Child Health Plus application and working with the New York City Human Resource Administration to conduct the required Aface-to-face@ interview for Medicaid applications and forwarding the completed applications to Medicaid;
- Supervising the enrollment process until student teams are comfortable completing the enrollment process without assistance;

[3] CDF-NY received generous support from the Commonwealth Fund, the United Hospital Funds, and the W.K. Kellogg Foundation to develop the SHOUT facilitated enrollment model.

- Training the students and CBOs; and
- Reviewing all Medicaid and Child Health Plus applications to ensure they are complete and accurate before forwarding them to the State Medicaid agency for processing.

Enrollment Results

Initial enrollment results for the SHOUT pilot project are encouraging. From October 1998 through January 1999, 172 children and adults submitted completed applications for Medicaid or Child Health Plus, resulting in 57 enrollments. It is important to note that Medicaid has 45 days from submission of a completed application to inform families of their acceptance.

Lessons Learned

The SHOUT project has been continually reevaluated through feedback received from student volunteers, CBOs serving as enrollment sites, and the families served. Highlights of some of the lessons learned throughout the SHOUT pilot project are:

- **Establishing an Infrastructure.** One of the greatest challenges for the SHOUT project was establishing an infrastructure and creating public awareness that would ensure families knew about SHOUT services. It was unfortunate that the SHOUT pilot project started prior to a statewide CHIP outreach campaign. In the future, it is anticipated that the State=s outreach efforts will be linked to the availability of community-based enrollment services.
- **Medicaid/Child Health Plus Documentation Requirements.** The documentation requirements associated with Medicaid, and to a lesser degree Child Health Plus, are often a barrier to enrollment. SHOUT diffused the confusion and difficulty around documentation by providing individualized review and follow-up by phone and mail. Consequently, only a few families who initiated an application with SHOUT did not return with their required documents.
- **Application Process.** Although there are still issues to be resolved, the joint Medicaid/Child Health Plus application makes the enrollment process less burdensome for families. In addition, SHOUT volunteers work extensively with families to explain unfamiliar health insurance terms, such as the concept of managed care. SHOUT program staff were surprised to learn that Medicaid eligibility workers applied enrollment criteria differently, especially in regards to required documentation. SHOUT is working with the State Medicaid agency to ensure consistent application of enrollment criteria.
- **Working with Students.** The SHOUT pilot project showed that there could be different roles for different students, from high school students doing direct outreach, to college students assisting families and processing enrollment applications, to graduate students serving as Supervisors. Because of the transient nature of student populations, due to matriculation and breaks, SHOUT found it beneficial to complement a network of part-time volunteers with more permanent staff at the CBOs.

Next Steps

In the coming academic year, CDF-NY will be working with Columbia University and its community-based SHOUT partners to institutionalize support for the program. For example, while CDF-NY would continue to provide technical support, including material development, training, and consultation, the CBOs and University campus could assume responsibility for student recruitment and coordination, day-to-day oversight of enrollment sites, and quality review of completed applications. Indeed, CDF-NY has received a grant to hire a project coordinator and part-time student organizers based at Columbia University. More specifically, CDF-NY will be working with other schools and communities to replicate the SHOUT model as CDF-NY is eager to work with students in any possible way to have them involved in CHIP outreach and enrollment activities.

Question and Answer Session

The following issues/questions, presented in a "Q & A" format, were raised during Ms. Katz's presentation:

Q: ***What knowledge/skill level is needed for volunteers?***

A: Ms. Katz indicated that the SHOUT student volunteers were knowledgeable. Each student volunteer received training in the classroom and on-site on such topics as eligibility, enrollment, and how managed care works.

Q: ***How are volunteers selected?***

A: For the SHOUT program, volunteers are selected through a random process based on whoever signs up to participate. Students work in teams, with a bilingual Supervisor. Those teams where half of the students were bilingual were placed in Washington Heights, while the other teams were placed in Harlem.

Q: ***How can the SHOUT model of facilitated enrollment be replicated in other States?***

A: Ms. Katz indicated that while CDF does not have a presence in every state, the intent is that the SHOUT model could easily be replicated in other cities across the Nation with partnerships between universities, colleges, CBOs, and State agencies. A State agency could easily assume the roles that CDF-NY conducted, such as recruitment and coordination, training, and day-to-day oversight (as noted above, over the next year, CDF-NY will be transferring some of its roles to either the campus entity or the CBOs). Furthermore, Ms. Katz noted that CDF-NY had received grants from the W.K. Kellogg Foundation and the Commonwealth Fund to develop the SHOUT pilot project. Conceivably, CBOs or Universities also could apply for similar grants.

Afternoon Discussion

A number of issues related to use of volunteers for CHIP outreach and enrollment were raised during the morning session. Two issues were selected for detailed discussion during the afternoon: 1) whether reimbursement is needed to pay for, and sustain, a force of CHIP outreach and enrollment volunteers; and 2) the role of a State "Ambassador"/Coordinator for volunteers. Each topic is discussed below.

Is Reimbursement Needed to Pay For, and Sustain, a Volunteer Force for CHIP Outreach and Enrollment?

The discussion on whether reimbursement is needed to pay for, and sustain a volunteer force for CHIP outreach and enrollment raised the following points:

- Few States pay volunteers for submitting completed CHIP/Medicaid applications. TAP participants were aware of only California and Louisiana as States that currently provide reimbursement for a completed CHIP/Medicaid application.
  - Other States, such as Pennsylvania and New York, have raised this issue with HCFA through questions and amendments to their CHIP applications.
- TAP participants discussed what impact a State paying some organizations for their enrollment assistance would have on those volunteers that are not paid. While this issue was not resolved, the point was made that States need to ensure that there is an adequate infrastructure in place to support its volunteers. For instance, the SHOUT program is seeking funding to pay for a Supervisor of the student network.
- A related question was raised: *What would States be paying for, outreach or outreach and enrollment?* Enrollment staff can take 30 to 90 minutes with a family to ensure proper translation of application requirements. It is important to differentiate what a State is reimbursing for, a completed CHIP/Medicaid application or as an investment in developing an infrastructure that supports the CHIP/Medicaid enrollment process. For volunteers to be successful, it is necessary that they have the proper support to become involved and have an impact.
  - **Louisiana** pays a $14 Aassistance fee@ per completed CHIP application submitted to the State. Before reimbursement is allowed, the application must be complete, meaning free of errors and with verifications attached. For verification, Louisiana requires the child applicant to have a Social Security number (not a card) and will accept alternative verification methods (food stamp record in lieu of a paycheck stub). The State receives five to six calls a day from organizations asking about becoming application assistance centers; however, only five to six a month follow through once they learn how much is involved. The State recently completed a training session for school-based health centers to become application assistance centers.
  - **California** is increasing its payment from $25 to $50 for each completed CHIP application (assuming all information has been verified).
- States could use more of their funds to train groups of volunteers to do outreach, with senior citizens identified as a potential pool of volunteers. It was noted that outreach workers in one site funded by the Robert Wood Johnson Foundation=s (RWJ=s) Covering Kids grant, carry laptops with State-designed software that determines eligibility. On a similar note, outreach workers could carry portable fax machines and fax completed applications from a family=s home to the State Agency. Some carry portable copy machines to assist with documentation materials.
- A TAP participant noted that some families targeted for CHIP enrollment do not respond to media efforts but rather require a trusted individual from the community going door-to-door and to church basements. The issue is: *How does a State price this service? On what basis? How does a State evaluate its success?*

- States could incorporate such activities, described as Aa cadre of arms and feet,@ into their outreach activities.
- States could provide mini-grants, based on a CBO=s plan to assist with CHIP/Medicaid enrollment and eligibility. Such mini-grants would enable CBOs to be flexible in their approaches and do not need to be large to achieve desired outcomes.
  - **New York** is implementing a mini-grants program that provides funding to coalitions that identify how they will involve every aspect of a targeted community to achieve the goal of informing families and enrolling children into Child Health Plus or Medicaid. The funds go to a designated lead agency that then pass the funds through to community-based subcontractors.
  - **New Mexico** has thought of an idea that would require any organization receiving State funds for CHIP/Medicaid outreach to devote a designated percentage to hire TANF workers.
  - **Massachusetts** has also implemented a mini-grants process for CBOs.
- HCFA is planning a fall outreach campaign that would provide a coordinated outreach effort with volunteers. HCFA is focusing this campaign on students returning to schools in conjunction with the Department of Education, the Department of Justice=s *5 Goals 4 Kids* coalition of private sector organizations, the United Way, Children=s Defense Fund, the National Council of LaRaza, and the American Hospital Association. Some State TAP participants expressed concern that increasing demand for enrollment could be burdensome especially if the turnaround time is insufficient.

<u>The Role of a State >Ambassador=/Coordinator for Volunteers</u>

- The discussion began with addressing whether or not the benefits from formalizing the role of a State coordinator for volunteers would add to a State=s bureaucracy. Each State TAP participant expressed its views:
  - **Louisiana** agreed that a full-time coordinator could alleviate the pressure of volunteer staff being individually involved in time-consuming activities, such as planning, gathering materials, designing, and scheduling presentations. However, Louisiana=s current decentralized structure of nine regional outreach coordinators works well**C**each regional outreach coordinator knows his/her region and how to communicate and work effectively within their communities.
    - With Louisiana=s decentralized structure, agency staff are taking on duties beyond their defined scope of responsibilities, which could lead to feelings of being overwhelmed.
  - In **Pennsylvania**, APenn Serve@ coordinates volunteer activities on behalf of the State. Even with this assistance, the full-time outreach coordinator for CHIP acknowledged that it is difficult for one person to fully understand and catalog all the organizations and volunteers that want to become involved in outreach. The State reports that it is not uncommon to receive five to ten calls a day wanting to find out more about CHIP and how they can become involved.
    - Pennsylvania=s central Medicaid department provides a liaison for each of the county-based Medicaid offices. The liaisons, whose duties include outreach, could benefit from a coordinator at the State-level who facilitates the integration of CHIP and Medicaid outreach activities.

- **Maryland**, like Louisiana, has a decentralized approach to outreach that uses the local health departments. As the Maryland Children=s Health Program matures, the State perceives the need to ensure congruity in the statewide message promoting CHIP and Medicaid across jurisdictions. It would be beneficial to have a State-level position to coordinate the various outreach activities of the local health departments by:
  - % Inventorying all outreach/enrollment activities of the local health departments;
  - % Assessing which activities were effective/ineffective (such as, how did one local health department successfully involve McDonald=s or K-Mart while another could not**C** is this due to ownership/franchising?); and,
  - % Following-up on a regular basis to ask the local health departments how they are doing.
- **New Mexico** has a full-time CHIP outreach coordinator; however, even at full-time, keeping up with radio talk shows and other presentations remains a challenge. The full-time position could easily use several part-time individuals for support.
  - % States should recognize that even with a full-time coordinator, what occurs at the local level varies considerably as outreach approaches are tailored to specific community needs.

- A volunteer outreach structure and approach that works effectively in one State might not work as well in another. The use of volunteers needs to be a thoughtful process that considers how volunteers will be: coordinated and organized; assured of participating in a meaningful process; trained; and evaluated. Having an infrastructure in place is key to sustaining the use of volunteers and maximizing their efforts.
- Different volunteer organizations performing outreach activities can place a unique Aspin@ on CHIP/Medicaid outreach materials to match their organizational charter. Such modifications can result in organizations disseminating inaccurate messages (refer to Louisiana=s presentation in **Attachment 2**).
  - To assist States, HCFA created the AInsure Kids Now@ outreach campaign and an accompanying Atool kit.@ The intent of the campaign and Atool kit@ is to provide a neutral message about the importance of health insurance that can be delivered anywhere and adapted by States and local communities.
- TAP participants were in agreement that effective outreach will make CHIP a success or failure, and that this message must be effectively communicated to legislators and the White House. Even with this acknowledgement, States face difficulties in seeking approval to expand current staffing resources. States, as well as HCFA and HRSA, have to add responsibilities to someone=s current job or staff someone from one project to another.
  - **Oklahoma** was cited as a State that successfully secured funding from its State legislature for positions devoted solely to CHIP/Medicaid outreach. TAP participants requested that the State consider writing a brief description of the methodology used so that other States could benefit from their experience.

State Requests for HCFA/HRSA Assistance

The following summarizes the requests made for HCFA/HRSA assistance by TAP participants from Louisiana, Maryland, New Mexico, and Pennsylvania.

1. Provide States with guidance and examples of how States compensate or reward volunteers, including:

_ Compile an inventory of States that provide a financial incentive to volunteers for completed applications, such as California paying $50 and Louisiana paying $14.

_ Conduct pilot studies around the country of the use of compensation for volunteers= ancillary assistance to States= outreach approaches to document the efficiency and effectiveness, through outcomes, of such activity.

_ Request the release of the RWJ study results, under the Covering Kids Initiative, on compensating volunteers.

_ Host a conference call with the HCFA Regional Offices, inviting interested States to discuss the topic of compensation for volunteers and then share this information with all States.

2. Determine which States permit access to birth records for eligibility determinations.

3. Work at the national level to encourage national organizations to get involved in the CHIP campaign so that States can provide support at the local and State levels.

1. Help States share information on volunteer >ambassadors= or coordinators (e.g., train-the-trainers).

5. Make available copies of the PA CHIP Public Service Announcements that were shown during Pennsylvania=s presentation.[4]

Closing Remarks

In closing, the co-chairs of the TAP, Dr. Gibbons and Ms. Galaty, thanked participants for sharing their experiences with the use of volunteers for CHIP/Medicaid outreach. They encouraged States to use HCFA=s Outreach Strategy Corner, www.hcfa.gov/initi/outreach, as a forum to exchange ideas, experiences, and lessons learned with one another. The information from this TAP will be available on HCFA=s website.

ATTACHMENT 1PARTICIPANTS (BASED UPON SIGN-IN SHEET) OF THEADVISORY PANEL MEETING

AEffective Use of Volunteers in CHIP Outreach and Enrollment Practices@HCFA Central Office, Baltimore, MarylandApril 22, 1999HCFA Central Office, Baltimore, Maryland, Media Room

Name	Organization	Phone Number
Bob Beardsley	NM Dept. of Human Services	505-476-6801
Dan Brant	PA Dept. of Health	717-787-7192
Betty Bumpers	Every Child By Two	202-783-7030
Medford Campbell	HCFA/CMSO/DEEO, CO	410-786-4457

[4] Contact George Hoover at Pennsylvania=s Department of Public Welfare, Division of Health Services at (717) 772-7809.

Name	Organization	Phone Number
Tina Cheatham	HCFA, Dallas RO	214-767-6497
Cheryl Dammons	HCFA/OCOS/CSSG, CO	410-786-4523
Valorie DeVonish	HRSA/BPHC, CO	301-594-4474
Tom Dunn	Barents Group LLC	202-739-8356
Michelle Everett	HCFA/CMSO/DEEO, CO	410-786-2017
Carol Galaty	HRSA/MCHB, CO	301-443-2778
Lil Gibbons	HCFA/CMSO/DEEO, CO	410-786-4523
Rosemary Field	HCFA, Philadelphia RO	215-861-4278
Dolores Finger-Wright	HCFA, Philadelphia RO	215-861-4186
Monica Harris	HCFA/CMSO/DEEO, CO	410-786-3335
Jeanette Hoffman	PA Dept. of Insurance B CHIP	717-705-4198
George Hoover	PA Dept. of Public Welfare	717-772-7809
Chris Howe	HCFA/CMSO/DEEO, CO	410-786-2005
Robin Iachini	HCFA/CMSO/DEEO, CO	410-786-7596
Barbara Jacquette	Queen Anne County Health Department, MD	410-758-0720
Sarah Katz	NY Children=s Defense Fund	212-697-2323
Susan Ledger	LA Dept. of Health and Hospitals	318-491-2169
Jean Maldonado	HCFA, Philadelphia RO	215-861-4252
Sandy Malone	MD Dept. of Health	410-767-6659
Jane McClard	HCFA/CMSO/DEEO, CO	410-786-4460
Jean Martin	HRSA/OA, CO	301-443-7070
Patsy Nelson	NM Department of Health	505-827-2504
Nancy Olsen	HCFA/CMSO/DEEO, CO	410-767-6659
Penny Pine	HCFA/OSP, CO	410-786-7718
Amy Pisani	Every Child By Two	202-783-7034
Rachel Quinn	Barents Group LLC	202-331-4524
Judy Rhoades	HCFA/CMSO/DEEO, CO	410-786-4462
Lisa Rogers	Barents Group LLC	202-331-4564
Marge Sciulli	HCFA/CMSO/DEEO, CO	410-786-0691
Kim Simonian	LA Office of Public Health	504-568-5073
Ned Wollman	MD Dept. of Health and Mental Hygiene	410-767-1464

Attachment 2

AEffective Use Of Volunteers InCHIP/MEDICAID Outreach And Enrollment@ B April22, 1999Technical Advisory Panel #6(Louisiana, Maryland, New Mexico, Pennsylvania)

This attachment provides summaries of each invited State=s presentation on its use of volunteers in CHIP outreach and enrollment. States with experience using volunteers were requested to address the following broad topics during their presentations:

_ Type of volunteer groups used;
_ The recruitment process;
_ Use of a State Ambassador/Coordinator;
_ Training of volunteers;
_ Monitoring of volunteers;
_ Retention of volunteers;
_ State plans to approach other organizations as volunteers; and
_ The pitfalls and benefits of using volunteers

States that were not using volunteers extensively or that were in the beginning stages of establishing relationships with volunteer organizations were requested to address the barriers or problems that had been encountered to date and suggest possible solutions to improve volunteer participation. The summaries of State presentations are provided in alphabetical order.

Louisiana (Ms. Susan Ledger and Ms. Kim Simonian)

Ms. Susan Ledger and Ms. Kim Simonian introduced themselves as the State TAP participants from Louisiana. Ms. Ledger is one of the regional employees of the Medicaid division responsible for LaCHIP, Louisiana=s Children=s Health Insurance Program. Ms. Simonian is a representative of the Louisiana Maternal and Child Health (MCH) program within the State Office of Public Health and the lead contact for Louisiana=s Covering Kids Initiative, a Robert Wood Johnson Foundation (RWJ) grant to conduct CHIP outreach that started April 1, 1999. Both the Medicaid division and the Office of Public Health are part of the Louisiana Department of Health and Hospitals (DHH), the umbrella agency that administers Medicaid and LaCHIP. For each component of their presentation, Ms. Ledger discussed the use of volunteers from the perspective of the Medicaid office, followed by Ms. Simonian discussing the same topic from the perspective of Louisiana=s Covering Kids Initiative.

Current Status of LaCHIP Implementation. Louisiana is in the early stages of implementing LaCHIP, a Medicaid expansion that began on November 1, 1998. As of mid-April 1999, Louisiana had enrolled 12,207 children into LaCHIP and 14,565 into Medicaid as a result of LaCHIP outreach and a streamlined enrollment process.[5] Louisiana emphasized that these results were obtained with

[5] During the planning stages of LaCHIP, Louisiana convened an Outreach and Enrollment Subcommittee that assisted in the design of a shortened application form, applicable to both LaCHIP and Medicaid, and the streamlining of enrollment

minimal outlays of resources--Medicaid did not hire new employees but rather depended upon volunteers.

Types of Volunteer Groups. Louisiana=s Medicaid division has adapted a definition of volunteers that uses its existing infrastructure of employees and partners to conduct LaCHIP outreach activities. The core group of volunteers consists of the 800 or more parish/county Medicaid employees, from management to clerical staff, as well as staff from other DHH agencies. These State employee Avolunteers@ have performed a variety of functions including: distributing LaCHIP holders with applications to sites within their communities; speaking to civic, humanitarian, and faith-based organizations; attending health fairs; appearing on radio and television talk shows; and coordinating the development of outreach plans that meet the needs of each respective region.

In addition, since 1992, Louisiana has outstationed the intake of Medicaid applications through Certified Application Centers (CACs). Currently, there are approximately 300 CACs and satellite offices throughout the State that assist individuals in the application process and who conduct outreach activities. CACs include, but are not limited to, such entities as health care providers, government agencies, faith-based organizations, and the Council on Aging.

Another source of volunteers from Louisiana=s perspective are the State and Local coalitions that the RWJ Covering Kids grant requires the State work with to implement LaCHIP outreach activities. The State has established the Louisiana Covering Kids Initiative Coalition that includes representation from child advocacy organizations, provider groups, CHIP and other health coverage programs, businesses, and the State agency responsible for welfare reform.

Activities under Louisiana=s Covering Kids Initiative include, but are not limited to:

- Expansion of the LaCHIP toll free helpline;
- Development and distribution of LaCHIP promotional materials targeted to non-English speaking families, working families who cannot afford health insurance, and former welfare recipients;
- A school-based campaign to educate parents about LaCHIP;
- Coordination of the eligibility processes of existing programs, such as the school lunch program with LaCHIP;

processes. This Committee includes Avolunteer@ representatives from community-based advocacy groups, Head Start, the American Association of Pediatrics, providers, and other State government agencies that serve children.

- Piloting one-on-one intensified outreach in two areas, one urban (New Orleans[6]) and one rural (Central Louisiana[7]), where the success of the basic outreach interventions can be compared; and
- Working with small businesses to assist them with enrolling employees= families into LaCHIP.

The Recruitment Process. Louisiana=s Medicaid division does not have a special initiative for recruiting volunteers. To recruit volunteers, each of the nine regions within Louisiana held one or more Launch Meetings designed to educate and inform organizations, groups, and employers who provide services to children about LaCHIP. Each region designed its own Launch Meeting invitation, program agenda, nametags, and decorations (such as, baskets of apples (the LaCHIP logo includes an apple), balloons, pens, and a cake with the LaCHIP logo). Through the Launch Meetings, approximately 120,000 application forms and holders were distributed; every Region ran out of applications and requested more. The Launch Meetings served as a primary source for spreading the word about LaCHIP, with Louisiana indicating **word of mouth** as one of its more effective tools for enlisting volunteers. For example:

> The Medicaid Regional Administrator=s secretary for Lafayette region took the initiative to call a local radio station to arrange an Aon-air@ interview for the Regional Administrator to discuss LaCHIP. This radio interview was heard by an employee of a Rubber Company and contacted the Regional Administrator to speak to the 70 employees of the Rubber Company. In the audience of the Rubber Company was the Human Resource Director, who belongs to the Human Resource Directors Association, who then asked the Regional Administrator to speak at a Human Resource Directors Association meeting.

The Louisiana Covering Kids Initiative has also used a simple recruitment process that is designed to enhance, rather than duplicate, Medicaid=s outreach efforts. The lead agency, the MCH office, determined what activities it wanted to conduct and identified who it would need to partner with in order to accomplish those activities. For example, Louisiana knew that it wanted to use its Covering Kids grant to involve schools into LaCHIP outreach, in a standardized manner using a top/down approach. The Louisiana MCH program met with the State Superintendent and elicited his commitment to promote the idea of LaCHIP outreach in schools to his Superintendents and to participate on the Louisiana Covering Kids Initiative Coalition. Louisiana has also had the opportunity to explain LaCHIP and the powerful role that schools can take in outreach to eligible children and their families to all of the State=s principals. The next step envisioned is to follow-up with principals on an individual basis to get them to promote LaCHIP through an announcement at a PTA meeting, a presence at report card night, or inclusion of material in the school handbook.

Recruitment of additional groups for the Louisiana Covering Kids Initiative was easier and more concrete. Because this was recruitment for participation in a grant, there was a concrete task that the MCH office could ask groups to do immediately--write a letter of support for the grant. Once the

[6] New Orleans is an urban area and the Orleans Parish includes a significant number of children who are uninsured and live in poverty-Bone-third of the State=s LaCHIP eligible population resides in New Orleans.
[7] Central Louisiana, including LaSalle and Concordia parishes, encompasses some of the poorest areas in the lower Mississippi Delta area and the country.

nature of the grant, coordinated outreach for LaCHIP, was explained no group refused to participate. As is the case with Louisiana=s overall LaCHIP outreach effort, the Louisiana Covering Kids Initiative benefits from a Asnowball@ effect.

Major Language/Cultural Groups Within Louisiana. The main languages spoken in Louisiana, aside from English, are Spanish and Vietnamese. However, non-English speakers comprise less than 1.5 percent of Louisiana=s population. To date, LaCHIP enrollment is 60 percent African-American and 37.5 percent Caucasian.[8] Approximately 67 percent of enrollees have one or both parents employed; 5 percent live with a grandparent or other kin-care giver; and one-third live in two-parent households.

The Medicaid office has targeted non-English speaking populations for outreach and enrollment into LaCHIP, with the Louisiana Covering Kids Initiative proposing to pay for the translation of the application form. In addition, Coalition members are agreeing to advertise and distribute LaCHIP materials to targeted communities in their native languages.

State Ambassador/Coordinator. Louisiana does not have a formally designated Volunteer Ambassador/Coordinator for LaCHIP. The coordination of volunteers is decentralized, with the Medicaid office regarding its nine regional outreach coordinators as AState Ambassadors.@

Training of Volunteers. First and foremost in training volunteers, the Medicaid office stresses that LaCHIP is a worthwhile project. The Medicaid office has developed a series of materials for informing the public and for using at speaking engagements. These materials include, but are not limited to, a standardized speech for Medicaid workers (to promote consistency in the message across the State); a LaCHIP fact sheet; Frequently Asked Questions; and a series of Power Point presentations that use easy-to-understand language, no abbreviations, and no acronyms. One tip Louisiana gave TAP participants was *to give detailed information about **whose** income is counted and not counted*. Often this information is new to volunteers who do not realize that grandparents=, stepparents=, aunts=, uncles=, and education income are not counted.

In addition to training, prior to implementation, the Medicaid office took several important steps to simplify the application process. The application was condensed from 14 pages to one page, front and back. Potential enrollees can mail-in the application and the requirement for a face-to-face meeting has been eliminated. A one-year continuous enrollment period has been instituted. Louisiana did not opt to use self-declaration; instead, applicants can submit alternative verifications if more Atraditional@ verifications are unavailable. Louisiana=s Medicaid eligibility staff has been advised to not request any extraneous to certification.

Louisiana=s Covering Kids Initiative, at the time of the TAP, had just been notified of its award, but envisions using a Atrain the trainer@ approach, similar to the Medicaid office=s use of Launch Meetings. Key Covering Kids State staff and staff in the pilot areas will be trained; these individuals will then inform community groups about LaCHIP and, in turn, these groups will help identify, inform, and enroll the families they serve. One issue that both Medicaid and the Covering Kids Initiative are cognizant of is the importance of maintaining consistency and accuracy of training as it moves away from direct control by the Medicaid office.

[8] The other 3.5 percent includes: unknown at 1.5 percent; Asian or Hispanic at less than 1 percent; and American Indian at less than 0.5 percent (four small Federally recognized tribes).

Monitoring and Retention of Volunteers. Louisiana=s Medicaid office does not give outreach funds to volunteer organizations. Medicaid does reimburse 50 percent of the estimated administrative cost of completing an application, presently set at $14. Currently, this payment is only applicable to CACs and, to receive the reimbursement, all pertinent verifications must be attached to the application.

In order to monitor the effectiveness of its outreach efforts, Louisiana intentionally designed its application form to include the origination point. To date, the origination point can be traced back to over 1,000 different places. While the State, to date, has not held any formal meetings with its volunteer groups/organizations to monitor them, an open line of communication is always encouraged between CACs and the local Medicaid offices. The intent of the State is to resolve as expeditiously as possible any problems that could hinder the application process.

The State has experienced an excellent retention rate. Involved organizations are showing no signs of wavering interest and various volunteers have planned outreach activities well into Fall of 1999. In addition, a core group of Medicaid employees continue to do aggressive outreach. All participants recognize that outreach is an on-going effort.

The Louisiana Covering Kids Initiative has no experience yet with the monitoring and retention of volunteers. The current strategy for monitoring is to hold meetings three times a year at which Coalition members can report their activities. More importantly, there will be on-going communication with all partners through e-mails and memos.

Key to retaining volunteers is explicitly outlining volunteers= roles from the beginning. If volunteers understand why they are participating and what their respective roles are, they may be less likely to be inactive.

Involvement of the Business Community. The State Medicaid office has been approaching businesses on an informal basis to seek agreement to display LaCHIP applications or forwarding LaCHIP applications to their employees. Some businesses, such as local McDonald=s franchises, have agreed to send a LaCHIP application, with payroll checks, to each employee, and to display LaCHIP applications at each of their restaurants.

The Louisiana Covering Kids Initiative is targeting small businesses and employers who employ part-time help with the intent of presenting LaCHIP seminars to small businesses throughout the State. The MCH agency recruited the Secretary of the Department of Social Services to become a Coalition member. The Secretary had contacts and familiarity with the Small Business Administration through Louisiana=s welfare-to-work program.

One important aspect of business community involvement has been in-kind support and contributions, although Louisiana has not, to date, actively solicited in-kind support. For instance, two newspapers have allowed the Medicaid office to insert the LaCHIP application in their newspapers. One newspaper used it own machinery to stuff the newspaper, while a college sorority, as community service, stuffed the other newspapers. The State has also received offers to assist in designing posters and written materials targeting certain populations, and a major coalition of hospitals, with Tulane University, has offered to use their in-house marketing and design services to provide the Medicaid office with a camera ready copy.

Pitfalls and Benefits of Using Volunteers. Louisiana began by indicating the potential drawbacks associated with using volunteers:

- Lack of consistency, for example:
  - A full-page LaCHIP ad placed by a group of medical providers, appeared in two newspapers. The clip art images used could be interpreted by some as stereotypes and could be considered offensive. The group of medical providers provided no disclaimer. The LaCHIP logo was cut off and utilized poor wording. The newspaper ads were published without the Medicaid office=s approval or prior knowledge.
- Maintaining confidentiality, which is stressed in the State=s training curriculum for individuals who will assist with enrollment.
- Coordinating volunteer efforts can be time-consuming.

However, there are numerous benefits to using volunteers, including:

- A mobilization of volunteers exhibiting a willingness to work hard at little or no cost to the State;
- A demonstration of creativity in approaches to reach the eligible LaCHIP population;
- The ability to maximize resources while reaching the largest number of eligible LaCHIP individuals for enrollment; and,
- An in-depth understanding of their communities and knowledge of how best to reach them.

Issues and Questions Raised During the Overview. The following issues, presented in a >Q&A= format, were raised during Louisiana=s presentation:

Q: ***What is included in the $14 administrative fee paid to CACs for processing successfully a LaCHIP enrollment application?***

A: Louisiana responded that the $14 is half of the estimated administrative cost, and includes such items as the cost of reproducing the enrollment form, collection of verification documents, and processing the paperwork.

Q: ***What is the role of CACs?***

A: Louisiana has developed an application for CACs[9] to complete, including standards of participation. The standards for participation include the types of entities eligible, training requirements, and agreements and responsibilities. Pennsylvania is considering implementing a similar program.

Q: ***Which Louisiana agency is responsible for eligibility?***

A: The Louisiana agency responsible for eligibility is the Louisiana Department of Health and Hospitals= Medical Vendor Administration. The Medical Vendor Administration has 45 days from the date of the application to determine eligibility.

[9] For more information about the CAC process contact Ms. Patrice Taylor of the Louisiana Department of Health and Hospitals= Medical Vendor Administration at 225-342-5716 or ptaylor@dhhmail.dhh.state.la.us.

Q: ***Does Louisiana have access to birth records in determining eligibility?***[10]

A: Louisiana responded that currently there is no State legislation that permits access to birth records to establish eligibility. However, in the absence of State legislation, the Medicaid office has negotiated with the Office of Public Health for access to vital statistics. The Medicaid Office had to ensure confidentiality would be maintained and only a limited number of individuals can access the birth records. It is a State-by-State decision whether or not to permit the Medicaid office to access vital records and HCFA/HRSA agreed to identify which States permit such access. It was noted that a ADear State Medicaid Director@ letter, dated October 22, 1998, addresses the sharing of information between State Medicaid and Health agencies.

Q: ***What is the role of the Regional Outreach Coordinator?***

A: Louisiana indicated that it had nine Regional Outreach Coordinators. Ms. Susan Ledger, one of the Regional Outreach Coordinators, is responsible for LaCHIP outreach to a five-parish area, with the assistance of other State employees. The role of the Regional Outreach Coordinator consists of recruiting volunteers and planning, gathering materials, designing materials, and scheduling presentations unique to each respective region.

[10] The Every Child by Two program supports the passing of legislation that enables a State=s CHIP/Medicaid program to access birth records.

Maryland (Mr. Ned Wollman, Ms. Barbara Jacquette, and Ms. Sandy Malone)

The Maryland presentation team introduced themselves. Mr. Ned Wollman is the Assistant Director of the Office of Medicaid Eligibility and Administration within the Maryland Department of Health and Mental Hygiene (DHMH), which has responsibility for administering the Maryland Children's Health Program (MCHP). Ms. Barbara Jacquette is a RN with the Queen Anne's Local Health Department and Ms. Sandy Malone is the Chief of Specialty Care within the Office of Children's Health of the Maryland DHMH.

Current Status of the Maryland Children's Health Program Implementation. Mr. Ned Wollman began by noting that Maryland's use of volunteers occurs at the local level, which is "where the rubber hits the road." MCHP, a Medicaid expansion, took effect July 1, 1998. Since then, 46,500 pregnant women[11] and children have been enrolled. Success in this effort is due, in large part, to the historical linkages and relationships between local health departments (LHDs) and their communities.

To simplify the application and enrollment process, Maryland has developed a three-page mail-in application. The State uses self-declaration and does not require verification (it was acknowledged that this may be problematic in the future but it is currently helping to enroll individuals). One goal of the State in implementing MCHP is establish processes and rules that do not impede enrollment efforts at the local level.

Type of Volunteer Groups/Partners. The State Medicaid office perceives its role as removing impediments to LHDs' efforts to enroll eligible individuals. The State serves as an interface with larger organizations with roots in the community and works with them to ensure they understand MCHP so that a consistent message takes hold. The State has cultivated relationships with a wide variety of partners who volunteer their resources to assist in outreach and enrollment. Affiliation between/among organizations and staff create a snowball effect by pulling an even wider variety of organizations into Maryland's outreach network. For example, Maryland's Hospital Association, with its local hospital members, has assisted the State's efforts with outreach and enrollment into MCHP and local hospitals have initiated their own efforts as part of their organizational commitment to the communities they serve.

The State Medicaid office spends a significant amount of time responding to phone calls and directing individuals to the local level. To provide an incentive to LHDs to increase the identification and enrollment of eligible children into MCHP, the former Secretary of Health and Mental Hygiene announced that those LHDs most successful in increasing MCHP enrollment would receive a monetary award from an available pool of $100,000. The first place winner was Queen Anne's County, which received $35,000.[12]

[11] Maryland's Governor, Parris N. Glendening, includes pregnant women because of the link between a healthy pregnancy and a healthy child.
[12] The second place winner received $25,000, the third and fourth place winners each received $15,000, and the sixth, seventh, and eighth place winners each received $5,000.

Queen Anne=s County Outreach Efforts. Ms. Barbara Jacquette, of the Queen Anne=s LHD, noted that Queen Anne=s County is the Agateway@ to the Eastern Shore and is basically a rural area that supports farming and seafood industries. It borders Caroline, Kent, and Talbot counties as well as the State of Delaware. A unique challenge for Queen Anne=s County is that it does not have a hospital, requiring residents to go to providers in each of the surrounding counties. Typically, hospitals serve as the Acontrol hub@ for outreach efforts in Maryland.

Queen Anne=s Success in Enrolling Eligible Children Into Maryland=s Children=s Health Program. The State estimated that Queen Anne=s County has 1,159 uninsured children, with 773 estimated to be eligible for MCHP. Of the 773 individuals estimated to be eligible, 386 were projected to participate in MCHP. As of January 1999, Queen Anne=s County had enrolled 486 of the individuals eligible under the expanded coverage into MCHP. Ms. Jacquette attributes this success to the team approach used by the LHD and the efforts of the community itself.

It was noted that Maryland has an 1115 waiver for managed care that called for a number of new roles and responsibilities of the LHDs. These responsibilities include: performing Medicaid/MCHP determinations; acting as the ombudsman program for individuals in managed care; and administering the State=s EPSDT program, Healthy Kids, through the Administrative Care Coordination Unit (ACCU). Because of the LHD=s small size, the staff must coordinate their efforts across several programs, such as ACCU has to coordinate its outreach efforts with those for the MCHP. The effect is that staff can see the Abig picture.@ Queen Anne=s County=s efforts began internally to ensure that all staff were well informed; from there, a ripple effect occurred through outreach to families, provider offices, and businesses and participation in community events, local news shows, and radio programs. In essence, the Queen Anne=s County LHD uses its staff as a pool of volunteers to elicit the involvement of community-based organizations.

State and Queen Anne=s County Outreach Materials. The State of Maryland distributes standardized outreach materials that each County can use or adapt for its outreach efforts, including the MCHP application, brochures, flyers, and a variety of color-coded and audience-specific Afact sheets.@[13] Queen Anne=s County has created its own specific MCHP outreach materials including, but not limited to:

- A local version of the State-developed flyers, such as a Christmas Flyer that includes holiday graphics and a message of AGive Your Family a Precious Gift B Health Insurance.@ The LHD has also sent fact sheets to local businesses, such as crab houses, to provide to their employees.
- A series of 18-inch, unique free-standing cardboard dolls, with each doll presenting an enrollment scenario and how Maryland can help; the dolls were used as part of an awareness campaign in April 1999, the Month of the Young Child:

  > AHi! My name is Lucy. I am 5 years old. Earlier this week, I was sick and crying with an earache, but Mommy and Daddy couldn=t take me to the doctor because it cost too much. Daddy works all week, but our family has no health insurance. Today, the had to take me to the Emergency Room and I was admitted. I know it will take my family a long time pay for this. **How Can We Help?** You may be eligible for the new

[13] Specific-audiences for the Afact sheets@ include children and pregnant women; community-based organizations; and providers.

Maryland Children=s Health Program, even if both Mom and Dad are working. Call us to see if you qualify.@

_ Submitting ALetters to the Editor@ and newspaper articles.

Community Events/Community Partners. The State alone cannot begin to reach, inform, and promote MCHP to all those eligible. Involvement in community events and partnerships with community organizations are, therefore, critical to the success of the Program. Queen Anne=s County has distributed MCHP information through a variety of community events and partnerships including, but not limited to:

_ Placing flyers at video stores, libraries, doctor=s offices, beauty shops, post offices, convenience stores, supermarkets,[14] bowling allies, and auctions.

_ Attending community events, such as 4-H Fairs, which are popular in Maryland, and the Wetlands Festival.

_ Coordinating with other LHD and State programs, such as the Dental Program sending a flyer with its fluoride mailing and the Maryland State Board of Education sending a flyer with every report card.

_ Attending migrant worker meetings during the summer.

_ Visiting every school and providing information to the school nurses, school counselors, and a school psychologist.

_ Meeting with each health care provider in Queen Anne=s County and providing information to office staff in the Fall of 1998.

_ Involving local churches in making a brief announcement about the availability of MCHP.

_ Contacting a representative of the Watermen Association and mailing a flyer to every member with a commercial fishing license.

The public has been receptive to these efforts. Individuals and communities are glad to see children receive comprehensive health benefits.

State Linkage Between Public Health and Medicaid. Ms. Sandy Malone, Chief of Specialty Care within the Office of Children=s Health of the Maryland DHMH, explained that she serves as a link between Medicaid/Public Health and State=s LHDs through management of the Children=s Medical Services Program. The Children=s Medical Services Program serves approximately 6,000 children with special health care needs. The State is in the process of transitioning eligible individuals with special health care needs into the Maryland Children=s Health Program; currently, about 70 percent of the children have transferred into MCHP. This presents an opportunity for the Office of Children=s Health to reposition itself by focusing on delivery of health services to the undocumented,

[14] The LHD approached K-Mart to see if it would be willing to place fliers in shoppers= bags and display posters, which K-Mart could not do. K-Mart did agree to allow fliers to be placed on its Service Desk. Supermarkets, on the other hand, have readily agreed and call the LHD when they are running low on flyers.

the underinsured, and those who age-out of MCHIP (Children=s Medical Services applies to children through age 21).

Community-Based Partners. The Office of Children=s Health also partners with community-based organizations to ensure effective outreach through various activities, including, but not limited to:

- Working with Parents Place and the Maryland chapter of Family Voices to do outreach as these organizations conduct family interviews identifying other siblings who may be eligible.
- Offering a 1-800 number Children=s Health Resource Line, which is in addition to the 1-800 number of MCHP.
- Partnering with the Shriner System. The Shriner System provides free health care. While Maryland does not have a Shriner Hospital, some 1,000 Maryland children are seen annually through the Shriner=s System. Shriner=s sponsors a number of clinics in Maryland each year where MCHP applications are evaluated.
- Working with the LHDs, as they serve as a referral source for the Children=s Medical Services Program.

The Office of Children=s Health has recently begun a newsletter for providers and families which will be used for outreach.

Issues and Questions Raised During the Presentation. The following issues, presented in a >Q & A= format, were raised during Maryland=s presentation:

Q: ***What does Queen Anne=s County ask volunteer organizations to do; what are volunteer organizations paid; and what type of training do they receive?***

A: Queen Anne=s County asks its volunteer organizations to distribute outreach materials, such as flyers, posters, and brochures, and MCHP applications. Currently the LHDs and the State do not pay volunteer organizations. Volunteer organizations are provided informal training, such as fact sheets, and, when requested, the LHD will do formal presentations. The one exception is providers whose office managers, under a grant from Advocates for Children and Youth, are being targeted for specific training.

Q: ***What outreach has been done with migrant workers, such as partnering through Rural Ministries?***

A: Queen Anne=s County staff work closely with the migrant summer program through a regional effort. The LHD coordinates the provision of health screenings through the use of Choptank Community Health System and the University of Maryland=s well-mobile.

Q: ***Have any groups been resistant to being enrolled into MCHP?***

A: The one specific population identified by the Queen Anne=s County LHD as reluctant or hesitant to apply for enrollment of their children MCHP was the watermen. However, some progress is being made. This progress is due, in part, to the fact that eligibility and enrollment for MCHP is conducted by the LHD. Consequently, the watermen associate MCHP with the LHD rather than with welfare or cash assistance.

Q: ***Does Queen Anne=s County have a sense of which volunteer organizations have been most successful in conducting MCHP outreach?***

A: Queen Anne=s County noted that it is difficult to assess which volunteer organizations have been the most successful in conducting MCHP outreach as the sources of applications have not been tracked. Queen Anne=s County contributes its overall success in enrolling eligible children into MCHP to the variety of organizations and agencies involved. The LHD noted that penetration into the migrant population has probably been minimal, while the targeting of families has been more extensive and successful. Many of the families know and trust the LHD eligibility workers and are comfortable communicating with them.

New Mexico (Mr. Bob Beardsley and Ms. Patsy Nelson)

The New Mexico presentation team introduced themselves. Mr. Bob Beardsley is the Acting Chief of the Client Services Bureau within the New Mexico Human Services Department and Ms. Patsy Nelson is the SCHIP Phase II Manager, Public Health Division, within the New Mexico Department of Health (DOH).

New Mexico=s CHIP Approach B Phase I & II. Mr. Beardsley began New Mexico=s presentation by noting that New Mexico currently has 1.7 million residents, 45 percent are Hispanic and 10 percent are Native American. Phase I of New Mexico=s Children=s Health Insurance Program was approved by HCFA on January 11, 1999 to expand its existing Medicaid Program. Under Phase I, Medicaid eligibility is expanded to children age 0 through 18 with family incomes up to 235 percent of the federal poverty level (FPL).[15] New Mexico=s CHIP funds are restricted to children in families between 185 percent and 235 percent of poverty. The benefits of Phase I are the same as the State=s Medicaid Program. Children in families between 186 percent and 235 percent of the FPL are subjected to various co-payments. New Mexico is currently developing Phase II, which will expand Phase I Medicaid services to include targeted wrap-around services that would be available to all children enrolled in Medicaid. Unlike Phase I, these services will be managed through the Department of Health (DOH) and the Children, Youth, and Families Department (CYFD).

In July 1998 New Mexico implemented New MexiKids, its outreach and enrollment initiative. New MexiKids includes implementation of the Presumptive Eligibility (PE) option enacted by the Balance Budget Act of 1997 requiring Medicaid On-Site Application Assistance (MOSAA) and twelve month continuous eligibility to further increase and facilitate the enrollment process of Medicaid and Salud!, New Mexico=s managed care program. PE enables any child to receive health insurance, without any income documentation, for up to 60 days while his or her Medicaid application is being processed. An applicant first completes a one-page information sheet that the PE determiner uses to indicate initial eligibility. The PE determiner then has up to ten days to work with the applicant on-site to gather the necessary documentation for verification and to complete the actual CHIP/Medicaid application. The PE determiner then forwards the completed application and materials to the local Income Support Division (ISD) office, which is responsible for determining the eligibility of an application and final processing.

Types of Volunteer Groups. Many State agencies, community organizations, and providers in New Mexico are certified PE determiners and MOSAA sites or volunteer their time to conduct outreach and enrollment activities. Examples of the type of volunteer groups involved in outreach and enrollment activities include, but are not limited to:

- State agencies, from the DOH and its 52 local offices, to the CYFD, to the Department of Labor and the Motor Vehicle Division Offices;
- The Indian Health Service (IHS) and Tribal Programs;

[15] In New Mexico there are approximately 94,500 uninsured children with family incomes under 185 percent of the FPL; 5,500 children with family incomes between 185 to 285 percent of the FPL; and 9,900 children with family incomes over 235% of the FPL.

- New Mexico Veteran Centers;
- Providers, including hospitals, managed care plans, and pharmacies, as well as health professional organizations, such as Pediatric associations;
- County Maternal and Child Health (MCH) Councils;
- Conference of Churches;
- Schools, community-based organizations, and special needs community contractors; and
- Businesses and Civic Organizations, such as the Lions and Kiwanis.

Types of Outreach and Enrollment Activities. New Mexico has implemented a multi-facet approach to outreach that includes such activities as direct mail, health fairs, presentations, and media events. Some highlights of outreach activities include:

- Schools publishing New MexiKids articles and coupons in school newsletters.
- The Conference of Churches conducting direct mailings that include New MexiKids materials as well as advertising the New MexiKids logo in church bulletins.
- Community-based organizations, businesses, health professional organizations, and managed care organizations holding health fairs. Health Fairs are very successful to target and enroll eligible families, with the State estimating that thousands of families and their children having been targeted to date. Promotional items that appeal to both young and old audiences are disseminated at the health fairs, such as frisbees, water bottles, rulers, growth charts, band-aids, and coloring books and crayons. The State also conducts AHighway to Health@ tours to explain New Mexico=s use of managed care for CHIP/Medicaid.
- The State ran a media campaign from October/November 1998 through March 1999 where New MexiKids was advertised in local newspapers and radio stations. *Radio spots were deemed by the State to be most successful,* with three spots a day over 21 days. Most stations then matched with another additional three spots. The spots were done in English, Spanish, and Navajo; those in English and Spanish were done by a local, popular TV personality. For Native American outreach, another successful strategy was to place ads in AIndian Country Today,@ a national publication read by many Native Americans in New Mexico.

Training Volunteers. Volunteers are required to complete a two-day training course before becoming certified PE and MOSAA determiners. Training courses are offered regionally through the different counties or directly through the State. The training course curriculum includes comprehensive lessons on Medicaid in general, eligibility, CHIP, and the PE/MOSAA process. Refresher courses are also offered. Upon completion of the course a volunteer is then certified and notification of their certification is sent to the responsible lead agency (the State certifies the lead agency, which then registers its specific providers). The responsible lead agency forwards the certification to the State so that the specific provider can be entered into the system. New Mexico is able to track where each application comes from because each certified agency has been given a number.[16]

[16] Approximately 25 percent of the applications come from the DOH; 25 percent from schools; 25 percent from the INS; and 25 percent from other providers.

Recruiting Volunteers. Ms. Patsy Nelson continued New Mexico=s presentation by discussing efforts to recruit volunteers from the various minority groups in New Mexico. New Mexico, the fifth largest landmass in the United States, has a significant number of subgroup populations, including a Native American population that consists of three tribal entities--Pueblos, Apaches, and Navajo. New Mexico=s demographics make outreach efforts more challenging to reach subgroups and hard-to-reach populations. Many volunteer groups and agencies have established partnerships to target all subgroups and educate the minority populations about New MexiKids. State agencies and volunteer groups include:

- The Indian Health Service (IHS) & Tribal Programs. The DOH works closely and collaboratively with the IHS and various tribal programs, which in turn educate their respective tribes. The IHS also displays New MexiKids signs and posters on informational boards within their health clinics.
- Covering Kids Grant Pilot Projects. New Mexico is a recipient of a Robert Wood Johnson Covering Kids Grant for outreach. Under the grant, New Mexico has created three pilot projects targeted at different populations and areas within the State.[17]
- DOH Public Health Division and Children, Youth, and Families Department. These agencies help target and perform outreach to others, including African Americans and Asians.

History of Volunteerism. Volunteers and volunteer groups have been active in New MexiKids since its inception. Not only does the State of New Mexico benefit from volunteers= service, but also the volunteers receive an invaluable experience. The volunteerism process teaches volunteers and volunteer groups the strategy behind decisions and stirs an interest in a cause that can potentially lead to buy-in. Many of the State=s volunteers ultimately become PE determiners. Volunteers have been actively involved in New Mexico=s outreach and enrollment approaches in many different ways, including:

- New Mexico Pediatric Society Task Force. This task force, made up of over 500 volunteers, helped craft and design SCHIP Phase II by conducting research and sharing its results with eight committees in the State. The Co-Chair of the Legislative Oversight Committee stated that this task force and the resultant SCHIP Phase II Amendment development in concert with the New Mexico legislature, tribes, volunteers, and State agencies is AState government at its best.@
- Various Other Coalitions. Volunteer groups have also been active participants or served in a variety of coalitions, including, but not limited to: the Covering Kids Coalition; the School Health Advisory Council; County MCH Councils; Healthier Communities; Human Needs Coordinating Council; and Developmental Disabilities Coalitions.

[17] The Native American pilot project (Navajo Nation on the Ramah Reservation) involves non-profit organizations training consumers to become informed consumers; this is done through the development of a brochure that helps them understand the concept of health insurance, such as comparing MCOs with IHS health insurance. The Border pilot project (Dona Ana County) consists of increasing the number of available promotoras, or lay health workers, meeting with undocumented Hispanic parents in their homes to provide outreach and assistance with the New MexiKids application. The Rural pilot project (Torrance/Valencia Counties) involves identifying and addressing barriers to outreach.

State Ambassador/Coordinator. New Mexico does not have one full-time State Ambassador/Coordinator for volunteers. The Medicaid Outreach Coordinator in the Human Services Department wears the official hat of the coordinator of volunteers. The coordinator=s duties include conducting presentations and community events with the volunteers; managing the marketing of New MexiKids= media and materials; and training volunteers.

Monitoring the Effectiveness of Volunteers. New Mexico acknowledged that it has not done much in the area of monitoring to date. New Mexico does require PE determiners to strive for a 90 percent MOSAA completion rate.

Feedback To And From Volunteers. New Mexico strives to have a good relationship with volunteers and provides opportunities for the volunteers to share ideas and address problems with the State. New Mexico shares information with volunteers through Provider Information Memos (PIM), a numbered memorandum system used by the State. PIMs answer volunteers= questions and ask for feedback, such as what volunteers like and dislike about their duties. The State has some quantifiable objectives that can be used to monitor volunteers, such as PE determiners and MOSAA sites should be submitting correct, completed applications 90 percent of the time. Other avenues through which the State receives feedback include the Native American Outreach and Enrollment Workgroup and the MOSAA determiners on how long it takes them to complete applications. Finally, feedback is exchanged in meetings with volunteers, such as at refresher courses, contractors, and the Covering Kids pilot projects.

Retention of Volunteers. To date, New Mexico has not experienced a high turnover of volunteers. Currently 721 individuals and provider entities are PE determiners and MOSAA sites, an indication that most are satisfied and want to continue. In mid-April 1999, New Mexico sent a letter to the certified lead agencies with PE determiners and MOSAA sites asking if they would be interested in conducting recertification activities. New Mexico monitors turnover closely and attributes turnover to two factors: 1) volunteers are leaving their organizations for new career paths; and 2) volunteers are requesting compensation that the State is unable to provide.

Future Recruiting Strategies. New Mexico is planning new recruiting strategies to increase volunteer involvement in outreach and enrollment activities including, but limited to:

- Targeting more businesses and the business community for volunteers;
- Leveraging previously existing relationships with the Hispanic Chamber of Commerce, the second largest in the country;
- Partnering with the Public Service Company of New Mexico, such as placing New MexiKids stuffers in bills; and
- Partnering with private insurance agents who have recently approached the State to become involved in New MexiKids outreach as a gesture of goodwill.

Benefits and Pitfalls of Using Volunteers. The State recognizes that New MexiKids would not be as successful without the hard work and involvement of volunteers and volunteer groups. The State of New Mexico, the clients, and volunteer organizations all benefit when volunteers are used or participate in New Mexico=s outreach practices:

- For the State of New Mexico
  - Increased enrollments[18]
  - Volunteer partners help once they become adept, as clients coming into their doors are comfortable and feel that they can trust them.
  - Volunteers help recruit ISD workers
- For Volunteer Organizations
  - With PE and MOSAA, clients no longer need to go to ISD offices to enroll
  - Providers know that they will be paid for health services rendered to eligible clients
- For Clients
  - Reduced Stigma
  - No need to go to Awelfare@ officeCinstead, clients are interacting with familiar and friendly staff in public health offices, schools, providers= offices, Head Start facilities
  - Additional and closer locations (for example, there are 52 public health offices compared to 32 ISD offices)
  - Public Health offices have immunization records for proof of age
- Native American Clients
  - Volunteers help alleviate and eliminate barriers such as language; distance; lack of phones; and mail being delivered once a week
  - The RWJ Covering Kids Grant has helped recruit volunteers, as well as identify and resolve barriers

Besides the many benefits of using volunteers, the use of volunteers also creates some problems to the State and to the groups themselves:

- For the State of New Mexico
  - It is time consuming to train staff and accommodate training needs, especially since State agencies are down-sizing and eliminating staff
  - There is the potential for misinformation and errors, such as deeming a 19 year old eligible for New MexiKids.
- For Volunteer Organizations.
  - Involvement is time consuming

[18] In June 1998, there were 173,000 children enrolled in Medicaid and by April 1999 there were 192,000 children enrolled, a 10 percent increase in enrollment. Moreover, New Mexico set as a target to enroll 5,500 children into New MexiKids. In one month, New Mexico enrolled 667 children, approximately twelve percent of its target enrollment goal.

- There is no compensation
- Organizations are having their number of full-time employees cut and, as a result, staff could be reassigned to different locations or locations serving different clienteles and may face additional work.

Issues and Questions Raised During the Overview. No issues were raised during New Mexico=s presentation, but one TAP participant shared comments about tapping into Greek organizations as a potential source of volunteers. Greek Organizations, national fraternities and sororities, are a rich source of volunteerism. The TAP participant encouraged States to link with these organizations and utilize their services because Greek Organizations are mandated to provide community service.

Pennsylvania (Ms. Jeanette Hoffman, Mr. Dan Brant, Mr. George Hoover)

The Pennsylvania presentation team introduced themselves. Ms. Jeanette Hoffman is the Outreach Coordinator for Pennsylvania=s Children=s Health Insurance Program, referred to as PaCHIP. She is responsible for developing and coordinating outreach strategies and materials that create awareness of PaCHIP and encourage families to enroll. Mr. Dan Brant is the Director of the Division of Maternal and Child Health in the Pennsylvania Department of Health with responsibility for the direction of a group of primary and preventive public health programs for pregnant women, infants, and children. Mr. George Hoover is the Director of Medicaid Eligibility Policy of the Office of Income Maintenance within the Department of Public Welfare, the Department responsible for administering Pennsylvania=s Medicaid program.

Types of Volunteers. Ms. Hoffman began Pennsylvania=s presentation by describing the State=s outreach activities and volunteerism. Pennsylvania has organized and stratified its volunteer groups into five categories:

1. Governmental.
2. CHIP Contractors.
3. Medical Community.
4. Child Advocacy Community.
5. Service/Professional Organizations.

PaCHIP Outreach Strategy Using Volunteer Organizations. Pennsylvania=s outreach strategy, described as Aan aerial attack,@ is a multi-faceted approach that includes the use of billboards, television ads, radio spots, newspaper articles, movie ads, kiosks, bus ads, brochures, posters, a toll-free help line, and a dedicated website. Pennsylvania contracts with a social marketing firm to provide and/or monitor the media and related components (such as websites, tool-free hotlines). A host of entities, within the categories listed above, are used by the State Ato collaborate with and infiltrate@ CHIP information on a statewide basis. Some examples of how these various organizations are involved in volunteer outreach capacities include:

- Penn Serve, an organization that assists the State in coordinating volunteer activities, identified some 25 agencies with volunteers that could become involved with CHIP outreach. Penn Serve and the Department of Labor and Industry drafted a letter signed by their respective Executive Directors that was sent to the 25 agencies to encourage them to use their employees as volunteers in distributing over 18,000 PaCHIP brochures to their customers.
- Members of the State Legislature receive posters and brochures from the State to distribute to their constituents.
- The Interfaith Justice Community, representing all the major religions, agreed to distribute PaCHIP brochures to their churches throughout the State.
- Philadelphia=s Chapter of America=s Promise, with Hope for Kids, sponsored a one-day canvassing of communities to disseminate over 25,000 PaCHIP informational packets in April 1999, with the State estimating that some 30,000 children will be affected by their efforts.

Video Presentation. Pennsylvania presented a series of videos, in English and Spanish, produced for CHIP, Medicaid, and the MCH program, ALove=Em with a Check-Up.@ The CHIP videos use the theme AI=m covered,@ featuring children wearing baseball caps with the PaCHIP logo. The text focuses upon the following points: the need for all children to have health insurance; that PaCHIP is not welfare; and that PaCHIP is for working families. The ALove=Em with a Check-Up@ videos use as a theme Alove your child with a check-up so that your child can love you forever.@ The videos are targeted to informing individuals without health insurance that they can receive check-ups for their children to enable them have a good start in life.

Mr. George Hoover noted that the Medicaid videos were produced to address confusion over the delinking of welfare from Medicaid. The videos inform individuals that when they go off welfare they can keep medical assistance. The original airing of this video over a one week period in Philadelphia resulted in a tremendous number of calls to a dedicated 1-800 phone number from individuals asking for assistance. Pennsylvania also showed a video, made in 1993 by the Medicaid division, that depicts an individual going through the eligibility process. This video is used by the State to encourage individuals to become volunteers.

Medicaid Outreach. Mr. Hoover then described a two-day meeting held by the Office of Income Maintenance on April 13-14, 1993. The purpose of this meeting was to encourage community agencies and organizations to act as outreach sites for the Medicaid program by distributing brochures; making applications available; and helping clients complete the applications. Participants of the meeting were given a Ablueprint@ of Medicaid outreach, including recent county-specific examples, Departmental contact names, and outreach materials (such as videos, sample applications, news releases, and information on public service announcements). As a result of this meeting, approximately 1,800 community agencies and groups, located throughout the State, volunteered to assist the Medicaid County Assistance Offices (CAOs) in Medicaid outreach efforts. The CAOs continue to be actively involved with communities in promoting the Medicaid program. In closing, Mr. Hoover noted that the Office of Income Maintenance is committed to taking all necessary actions and activities to ensure that the children of Pennsylvania have health insurance.

Corporate Volunteerism. Mr. Dan Brant noted Pennsylvania has several corporate volunteers that have provided assistance. For example, he cited BlueCross and BlueShield of Pennsylvania and the RiteAid Corporation as being very supportive through sponsorship of events and advertising (for instance, providing shelf hangers promoting ALove=Em with a Check-Up@ near children-oriented products, such as diapers, in pharmacies). He emphasized that it is important for a State to provide an infrastructure that enables the State to organize and coordinate its outreach efforts effectively, including outreach activities of volunteers.

Issues and Questions Raised During the Overview. The following issues, presented in a >Q&A= format, were raised during Pennsylvania=s presentation:

Q: ***How many children are currently insured in Pennsylvania?***

A: Pennsylvania responded that PaCHIP had 74,000 enrollees in April 1999 compared to 60,000 enrollees in July 1998. The State estimates that another 70,000 individuals are eligible for CHIP or Medicaid but not enrolled.

Q: ***How many volunteers in Pennsylvania are working with CHIP?***

A: Pennsylvania responded that volunteer numbers approach 300,000 statewide, the majority of whom are affiliated with an organization of some kind (such as churches, civic organizations, etc.). The Philadelphia chapter of America's Promise, in its annual report, reported from survey results the involvement of over 80,000 individuals affiliated with some 1,800 organizations were involved in various projects. The Medicaid Department is evaluating an outreach strategy that uses a trusted connection, such as using the Russian Center in Philadelphia to reach the Russian population.

Children's Defense Fund

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What's Working for Children's Health

Case Study

SHOUT Project

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Children's Defense Fund-New York has partnered with Columbia University and Community-Based Organizations (CBOs) in Northern Manhattan on a new and innovative project. The Student Health Outreach Project (SHOUT) is a unique program that aims to reach out to uninsured children in Northern Manhattan. The program includes graduate and undergraduate students from various departments within Columbia University. These students are trained by Children's Defense Fund-New York's outreach staff on how to complete the new joint Medicaid/Child Health Plus, New York State's Children's Health Insurance Program (CHIP) application. Students also receive cultural sensitivity training in the appropriate screening procedures for immigrants and other low-income populations. Once trained, these student volunteers are placed in CBOs to assist families with the enrollment process.

Through this program, many eligible uninsured children will be assisted with enrollment in Medicaid /CHIP. Students participating in SHOUT work in selected CBOs which serve populations that might qualify for Medicaid or CHIP. These student volunteers educate families about Medicaid and CHIP, screen families for eligibility, and assist families during the enrollment process. Each student volunteer agrees to serve at least two hours a week in a particular community-based organization. As a result of this commitment, students and CBOs serve as a reliable and continuous source of information for families.

The goal of the SHOUT project is to enroll all eligible children in Northern Manhattan in Medicaid or Child Health Plus. It will accomplish this goal by informing the maximum number of families about the availability of free or low-cost health insurance. These efforts will be carried out through an extensive public awareness campaign and by providing accessible enrollment sites with knowledgeable staff to offer guidance through the application process.

The Children's Defense Fund-New York has completed a report on The Student Health Outreach Project. This report contains detailed information on the various aspects of the project, including background information, the outreach campaign, and student recruitment.

For more information about the SHOUT program, please contact Sarah Katz, author of Children's Defense Fund-New York's report "The Student Health Outreach Project," at 212/697-2323or e-mail at Skatz@cdfny.org.

"What's Working" is a series of short reports by the Children's Defense Fund on successful outreach and enrollment efforts across the country.

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